notice for at least a 7-year period after the date on which such item or service is so furnished.

(f) Definitions

In this section:

(1) The terms ''nonparticipating provider'' and ''participating provider'' have the meanings given such terms, respectively, in subsection (a)(3) of section 300gg–111 of this title.

(2) The term ''participating health care facility'' has the meaning given such term in subsection (b)(2) of section 300gg–111 of this title.

(3) The term ''nonparticipating facility'' means—

(A) with respect to emergency services (as defined in section 300gg–111(a)(3)(C)(i) of this title) and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, an emergency department of a hospital, or an independent freestanding emergency department, that does not have a contractual relationship with the plan or issuer, respectively, with respect to the furnishing of such services under the plan or coverage, respectively; and

(B) with respect to services described in section 300gg–111(a)(3)(C)(ii) of this title and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, a hospital or an independent freestanding emergency department, that does not have a contractual relationship with the plan or issuer, respectively, with respect to the furnishing of such services under the plan or coverage, respectively.

(4) The term ''participating facility'' means—

(A) with respect to emergency services (as defined in clause (i) of section 300gg–111(a)(3)(C) of this title) that are not described in clause (ii) of such section and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, an emergency department of a hospital, or an independent freestanding emergency department, that has a direct or indirect contractual relationship with the plan or issuer, respectively, with respect to the furnishing of such services under the plan or coverage, respectively; and

(B) with respect to services that pursuant to clause (ii) of section 300gg–111(a)(3)(C) of this title, of section 9816(a)(3) of title 26, and of section 1185e(a)(3) of title 29, as applicable are included as emergency services (as defined in clause (i) of such section and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, a hospital or an independent freestanding emergency department, that has a contractual relationship with the plan or coverage, respectively, with respect to the furnishing of such services under the plan or coverage, respectively.

(July 1, 1944, ch. 373, title XXVII, §2799B–2, as added Pub. L. 116–260, div. BB, title I, §104(a), Dec. 27, 2020, 134 Stat. 2824.)

§300gg–133. Provider requirements with respect to disclosure on patient protections against balance billing

Beginning not later than January 1, 2022, each health care provider and health care facility shall make publicly available, and (if applicable) post on a public website of such provider or facility and provide to individuals who are participants, beneficiaries, or enrollees of a group health plan or group or individual health insurance coverage offered by a health insurance issuer a one-page notice (either postal or electronic mail, as specified by the participant, beneficiary, or enrollee) in clear and understandable language containing information on—

(1) the requirements and prohibitions of such provider or facility under sections 300gg–131 and 300gg–132 of this title (relating to prohibitions on balance billing in certain circumstances);

(2) any other applicable State law requirements on such provider or facility regarding the amounts such provider or facility may, with respect to an item or service, charge a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage offered by a health insurance issuer with respect to which such provider or facility does not have a contractual relationship for furnishing such item or service under the plan or coverage, respectively, after receiving payment from the plan or coverage, respectively, for such item or service and any applicable cost-sharing payment from such participant, beneficiary, or enrollee; and

(3) information on contacting appropriate State and Federal agencies in the case that an individual believes that such provider or facility has violated any requirement described in paragraph (1) or (2) with respect to such individual.

(July 1, 1944, ch. 373, title XXVII, §2799B–3, as added Pub. L. 116–260, div. BB, title I, §104(a), Dec. 27, 2020, 134 Stat. 2829.)

§300gg–134. Enforcement

(a) State enforcement

(1) State authority

Each State may require a provider or health care facility (including a provider of air ambulance services) subject to the requirements of this part to satisfy such requirements applicable to the provider or facility.

(2) Failure to implement requirements

In the case of a determination by the Secretary that a State has failed to substantially enforce the requirements to which paragraph (1) applies with respect to applicable providers and facilities in the State, the Secretary shall enforce such requirements under subsection (b) insofar as they relate to violations of such requirements occurring in such State.

(3) Notification of applicable Secretary

A State may notify the Secretary of Labor, Secretary of Health and Human Services, or the Secretary of the Treasury, as applicable, of instances of violations of sections 300gg–131, 300gg–132, or 300gg–135 of this title with respect

to participants, beneficiaries, or enrollees under a group health plan or group or individual health insurance coverage, as applicable[1] offered by a health insurance issuer and any enforcement actions taken against providers or facilities as a result of such violations, including the disposition of any such enforcement actions.

(b) Secretarial enforcement authority

(1) In general

If a provider or facility is found by the Secretary to be in violation of a requirement to which subsection (a)(1) applies, the Secretary may apply a civil monetary penalty with respect to such provider or facility (including, as applicable, a provider of air ambulance services) in an amount not to exceed $10,000 per violation. The provisions of subsections (c) (with the exception of the first sentence of paragraph (1) of such subsection), (d), (e), (g), (h), (k), and (*l*) of section 1320a—7a of this title shall apply to a civil monetary penalty or assessment under this subsection in the same manner as such provisions apply to a penalty, assessment, or proceeding under subsection (a) of such section.

(2) Limitation

The provisions of paragraph (1) shall apply to enforcement of a provision (or provisions) specified in subsection (a)(1) only as provided under subsection (a)(2).

(3) Complaint process

The Secretary shall, through rulemaking, establish a process to receive consumer complaints of violations of such provisions and provide a response to such complaints within 60 days of receipt of such complaints.

(4) Exception

The Secretary shall waive the penalties described under paragraph (1) with respect to a facility or provider (including a provider of air ambulance services) who does not knowingly violate, and should not have reasonably known it violated, section 300gg–131 or 300gg–132 of this title (or, in the case of a provider of air ambulance services, section 300gg–135 of this title) with respect to a participant, beneficiary, or enrollee, if such facility or provider, within 30 days of the violation, withdraws the bill that was in violation of such provision and reimburses the health plan or enrollee, as applicable, in an amount equal to the difference between the amount billed and the amount allowed to be billed under the provision, plus interest, at an interest rate determined by the Secretary.

(5) Hardship exemption

The Secretary may establish a hardship exemption to the penalties under this subsection.

(c) Continued applicability of State law

The sections specified in subsection (a)(1)[2] shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any requirement or prohibition except to the extent that such requirement or prohibition prevents the application of a requirement or prohibition of such a section.

(July 1, 1944, ch. 373, title XXVII, § 2799B–4, as added Pub. L. 116–260, div. BB, title I, § 104(a), Dec. 27, 2020, 134 Stat. 2829.)

§ 300gg–135. Air ambulance services

In the case of a participant, beneficiary, or enrollee with benefits under a group health plan or group or individual health insurance coverage offered by a health insurance issuer and who is furnished in a plan year beginning on or after January 1, 2022, air ambulance services (for which benefits are available under such plan or coverage) from a nonparticipating provider (as defined in section 300gg–111(a)(3)(G) of this title) with respect to such plan or coverage, such provider shall not bill, and shall not hold liable, such participant, beneficiary, or enrollee for a payment amount for such service furnished by such provider that is more than the cost-sharing amount for such service (as determined in accordance with paragraphs (1) and (2) of section 300gg–112(a) of this title, section 1185f(a) of title 29, or section 9817(a) of title 26, as applicable).

(July 1, 1944, ch. 373, title XXVII, § 2799B–5, as added Pub. L. 116–260, div. BB, title I, § 105(b), Dec. 27, 2020, 134 Stat. 2851.)

§ 300gg–136. Provision of information upon request and for scheduled appointments

Each health care provider and health care facility shall, beginning January 1, 2022, in the case of an individual who schedules an item or service to be furnished to such individual by such provider or facility at least 3 business days before the date such item or service is to be so furnished, not later than 1 business day after the date of such scheduling (or, in the case of such an item or service scheduled at least 10 business days before the date such item or service is to be so furnished (or if requested by the individual), not later than 3 business days after the date of such scheduling or such request)—

(1) inquire if such individual is enrolled in a group health plan, group or individual health insurance coverage offered by a health insurance issuer, or a Federal health care program (and if is so enrolled in such plan or coverage, seeking to have a claim for such item or service submitted to such plan or coverage); and

(2) provide a notification (in clear and understandable language) of the good faith estimate of the expected charges for furnishing such item or service (including any item or service that is reasonably expected to be provided in conjunction with such scheduled item or service and such an item or service reasonably expected to be so provided by another health care provider or health care facility), with the expected billing and diagnostic codes for any such item or service, to—

(A) in the case the individual is enrolled in such a plan or such coverage (and is seeking to have a claim for such item or service submitted to such plan or coverage), such plan or issuer of such coverage; and

[1] So in original. Probably should be followed by a comma.

[2] So in original. Subsec. (a)(1) specifies ''this part'', but does not specify individual sections.